ventilation—consider ventilating the adult patient at 6 breaths per minute (1/2 the normal rescue breathing rate).

3. If an Automated External Defibrillator (AED) is available, then proceed with one set of stacked shocks if the machine deems that this is indicated. If the core temperature cannot be determined or is above 86ºF, then follow guidelines for resuscitation as if the patient were normothermic. If the patient's core temperature is below 86º F (30º C), discontinue use of AED after the initial 3 shocks until the patient's core temperature has reached 86º F (30ºC).

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4. Contact OLMC:

   a. If CPR has been provided in conjunction with rewarming techniques for more than 30 minutes without the return of spontaneous pulse or respiration, contact OLMC for recommendations.

   b. If contact with OLMS is not possible, consider termination of resuscitation efforts after 60 minutes of CPR if no return of spontaneous pulse or respiration, and contact OLMC as soon as possible.

INTERMEDIATE

5. Warmed IV fluid may be necessary and given as bolus therapy (250-500 ml in normal adult; 20 ml/kg in peds), with repeating once if necessary. Use normal saline heated to 104º-108º F (40º-42ºC) if possible.

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6. Contact OLMC if a 3rd bolus is necessary.

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7. If an manage airway device needs to be placed (indications the same in normothermic and hypothermic patients), preoxygenate and adequately **ventilate for 3 minutes prior to placement of device.** Also, avoid hyperventilation as noted above—**give 6 breaths per minute in an adult** (1/2 the normal breathing rate).

CRITICAL CARE/PARAMEDIC

8. If ventricular fibrillation is present on the monitor, then one series of stacked defibrillations is OK. Shivering can mimic ventricular fibrillation. If the core temperature cannot be determined or is above 86ºF, then follow guidelines for resuscitation as if the patient were normothermic. If the patient's core temperature is below 86º F (30º C), discontinue defibrillation after the initial 3 shocks until the patient's core temperature has reached 86ºF (30ºC).
9. Antiarrhythmic medication or cardiac medications in general should be held until the patient is warm (> 86º F) and undergoing rewarming.

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10. Contact OLMC:
    a. If resuscitation has been provided in conjunction with rewarming techniques for more than 30 minutes without the return of spontaneous pulse or respiration, contact OLMC for recommendations.
    b. If contact with OLMC is not possible, consider termination of resuscitative efforts and contact OLMC as soon as possible.

CRITICAL CARE / PARAMEDIC

10. Administer:
    A. Midazolam (*Versed*) 0.02 mg/kg IV maximum 4 mg: or Lorazepam (*Ativan*) 0.03 mg/kg IV with a maximum of 2 mg: or contact OLMC if repeat dosing is necessary.
    B. Alternate routes to IV dosing:
    Intramuscular dosing – Midazolam (*Versed*) 0.2 mg/kg IM if IV cannot be estabilished to maximum dose of 10 mg. Lorazepam (*Ativan*) 0.04 mg/kg IM to a maximum dose of 4 mg IM. Buccal administration: Midazolam (*Versed*) 10 mg per buccal/mucosa; Lorazepam (*Ativan*) 0.05-0.15 mg/kg per buccal. Rectal administration: Midazolam 0.3 mg/kg to a maximum dose of 10 mg (Lorazepam is too slow here).

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11. Contact OLMC for the following OPTIONS:
    A. Naloxone (*Narcan*) 0.1-2 mg IV, IO **only give if depressed respirations and you suspect narcotic overdose,** titrate to improve respiratory drive; patients abruptly fully awakened may become combative, or suffer acute narcotic withdrawal symptoms. Some drugs such as Propoxyphene, Talwin, or Methadone may require high doses.
    B. Dextrose10% (1 ml of D_{50} in 4 ml IV fluid or use pre-mix IV, IO according to the above table.*
    C. Glucagon 0.5 mg IM (if IV, IO access is unavailable for administration of Dextrose).*

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* If seizure is secondary to trauma, without the possibility of hypoglycemia, **DO NOT** administer Dextrose or Glucagon.